Email:_____

Excellence In Dentistry

Patient Information

Name _____ Age _____ Birth Date _____

Sex: Male ☐ Female ☐ Soc. Sec. # _____ Home Phone _____ Cell Phone _____

Address_____ City/State/Zip _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If full time student, School Name & Address _____

Occupation _____ Employer _____ Work Phone _____

Employers Address_____ City/State/Zip_____

Whom may we thank for referring you? _____ In case of emergency, notify _____

Home Phone _____ Work Phone _____ Address/City/State/Zip _____

Former Dentist _____ Address/City/State/Zip _____ Phone _____

Date of last dental care _____ Date of last full mouth x-rays _____

How often do you brush? _____ Floss? _____ How do you feel about the appearance of your teeth? _____

Check if you have had problems with any of the following:

☐ Bad breath
☐ Bleeding gums
☐ Loose teeth or broken fillings
☐ Food collection between teeth
☐ Sensitivity to cold
☐ Sensitivity to hot
☐ Periodontal Treatment
☐ Sensitivity when biting
☐ Sores or growths in mouth
☐ Sensitivity to sweets

Primary Dental Insurance

Subscriber Name _____ Relation to patient _____ Birth Date _____

Sex: Male ☐ Female ☐ Soc. Sec.# _____ Home Phone _____ Cell Phone _____

Address_____ City/State/Zip_____

Occupation _____ Employer _____ Work Phone _____

Insurance Company_____ Phone _____ Group #_____

Additional Dental Insurance

Subscriber Name _____ Relation to patient_____ Birth Date _____

Sex: Male ☐ Female ☐ Soc. Sec.# _____ Home Phone _____ Cell Phone _____

Address_____ City/State/Zip_____

Occupation _____ Employer _____ Work Phone _____

Insurance Company_____ Phone _____ Group #_____

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs and authorizes their use in lectures/publications. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself, my dependants, or the patient named above is mine, due and payable at time of service. I also agree that I shall pay all costs incurred in collecting past due amounts (of more than 60 days) including reasonable attorneys fees. I further understand that a finance charge of 18% annually will be added to any overdue balance, a late fee may be added if my payment is late, and charges may be added for broken appointments. I also assign all insurance benefits to the Doctor.

Signature _____ **Date** _____

IF CONSENT IS GIVEN BY A PARENT/GUARDIAN, THE FOLLOWING INFORMATION IS REQUIRED:

Print: Name _____ Relation to patient_____ Birth Date _____

Sex: Male ☐ Female ☐ Soc. Sec. # _____ Employer _____ Work Phone _____
(If different than patient)

Home Phone _____ Cell Phone _____

Address_____ City/State/Zip_____

Please complete both sides.

Patient's Name **Date of Birth**

Health History

Answer all questions by circling Yes (Y) or No (N) All responses are kept confidential.

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? ..... Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: ..... Y N

   _____

   _____
6. Height _____ Weight _____
7. **Do you have or have your ever had:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? ..... Y N
   - B. Congenital Heart Disease? ..... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) ..... Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness ..... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? ..... Y N
   - H. Kidney Disease? ..... Y N
   - I. Diabetes? ..... Y N
   - J. Thyroid Disease (Goiter)? ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach Ulcers or Colitis? ..... Y N
   - M. Glaucoma? ..... Y N
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
   - O. Radiation (X-ray) treatment for Cancer? ..... Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
   - Q. Sinus or Nasal problems? ..... Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N
   - S. Osteoporosis or Osteopenia? ..... Y N
8. **Are you using any of the following:**
   - A. Antibiotics? ..... Y N
   - B. Anticoagulants (Blood Thinners)? ..... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? ..... Y N
   - D. High Blood Pressure medications? ..... Y N
   - E. Steroids (Cortisone, etc.)? ..... Y N
   - F. Bisphosphonates such as Fosamax, Actenol, Aredia, Zomeda, Boniva, Forteo? ..... Y N
   - G. Tranquilizers? ..... Y N
   - H. Insulin or Oral Anti-Diabetic drugs? ..... Y N
   - I. Digitalis, Inderal, Nitroglycerin or other heart drug? ..... Y N
   - J. Please list any and all medications taken, including prescription medications, over-the-counter mediations, herbal or holistic remedies, vitamins or minerals: _____

     _____

     _____

     _____
9. **Are you allergic to or have you had an adverse reaction to:**
   - A. Local Anesthesia (Novocain, etc.)? ..... Y N
   - B. Penicillin or other antibiotics? ..... Y N
   - C. Sedatives, Barbiturates? ..... Y N
   - D. Aspirin or Ibuprofen? ..... Y N
   - E. Codeine or other pain killers? ..... Y N
   - F. Latex or Rubber Products? ..... Y N
   - G. Other allergies or reactions? Please, list ..... Y N

     _____

     _____
10. Do you smoke or chew Tobacco? ..... Y N
    How much per day? _____
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ..... Y N
12. Have you had any serious problems associated with any previous dental treatment? ..... Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? ..... Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
15. Do you wish to talk to the doctor privately about anything? ..... Y N
16. **For WOMEN ONLY**
    - A. Are you Pregnant, or <u>is there any chance</u> you might be Pregnant? ..... Y N
    - B. Are you nursing? ..... Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Heath History with my doctor.

Date _____ Signature of Person Completing Health History _____ Doctor's Initials _____